Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PROVIDENCE ST. VINCENT MEDICAL CENTER
REHABILITATION SERVICE
9205 S W BARNES ROAD
PORTLAND OR 97225

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-06-7073-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Apparently some time after beginning his treatment here in Oregon, a new rule/regulation went into effect in Texas stating the prior authorization must be obtained regarding therapy visits. We regret that we were never informed of the implementation of the new change in rules, which resulted in denial of payment for services rendered at our facility. We are therefore submitting this request for payment of the denied amounts to our facility."

Amount in Dispute: $2,912.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated on the Respondents Table of Disuted Services: "previously paid pre-auth not obtained"

Response Submitted by: Insurance Co. of the State of PA, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 25, 2005	CPT Code 97001 ($62.52 x 125% = $78.15 – $96.86 (carrier payment))	$189.25	$0.00
November 25, 2005	CPT Code 97110 (2 Units) ($26.85 x 125% = $33.56 x 2 = $67.12 - $71.72 (carrier payment))	$144.50	$0.00
November 28, 2005	CPT Code 97110 (1 Unit) ($26.85 x 125% = $33.56 - $35.86 (carrier payment))	$72.25	$0.00
November 28, 2005	CPT Code 97140 (1 Unit) ($25.43 x 125% = $31.79 - $33.94 (carrier payment))	$73.00	$0.00
December 2, 2005	CPT Code 97110 (2 Units) ($26.85 x 125% = $33.56 x 2 = $67.12 - $71.72 (carrier payment))	$144.50	$0.00

December 5, 2005	CPT Code 97110 (1 Unit) ($26.85 x 125% = $33.56 - $35.86 (carrier payment))	$72.25	$0.00
December 5, 2005	CPT Code 97140 (1 Unit) ($25.43 x 125% = $31.79 - $33.94 (carrier payment))	$73.00	$0.00
December 8, 2005	CPT Code 97110 (2 Units) ($26.85 x 125% = $33.56 x 2 = $67.12 - $71.72 (carrier payment))	$144.50	$0.00
December 8, 2005	CPT Code 97035 (1 Unit) ($11.70 x 125% = $14.63 - $15.53 (carrier payment))	$40.75	$0.00
December 16, 2005 – January 18, 2006	CPT Codes 97110, 97035	$1,808.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the reimbursement guidelines.
3. The request for medical fee dispute resolution was received by the Division on July 3, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), amended to be effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 19, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule. The Requestor did not submit additional documentation. On August 11, 2006, the division notified the respondent that additional documentation was not provided by the requestor and the respondent now had 14 days to file additional information; the respondent complied with this request.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   EOBs were not submitted by the requestor for dates of service November 25, 2005 through December 29, 2005; Explanation of benefits submitted by the requestor dated February 2, 2006:
   - 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Procedure not approved by pre-authorization.

   EOBs submitted by the Respondent dated April 28, 2006:
   - Pay T – Reduced to fair and reasonable.
   - NSUB – Reimbursement for your resubmitted invoice has been considered, no additional monies are being paid at this time.
   - Auth – Reimbursement is being withheld as the treating doctor or services rendered were provided without authorization.
   - Resub: Auth – Services rendered were provided without authorization.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the Requestor obtain preauthorization as required by Rule 134.600 and is the requestor entitled to reimbursement?

Findings

1. The requestor provided physical therapy services in the state of Oregon December 5, 2005 through January 18, 2006 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor did not show proof of reconsideration; however, the respondent submitted EOBs showing payment was made on May 1, 2006 for dates of service December 5, 2005 through December 8, 2006. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for solution of the matter of non-payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.

2. Per §134.600 physical and occupational therapy services rendered between December 1, 2005 and May 2, 2006 did not require preauthorization for the first two visits following an examination if the treatments are rendered within the first two weeks following the date of injury or a surgical intervention previously approved by the insurance carrier. The respondent submitted EOBs showing payment was made to the requestor for

dates of service November 25, 2005 through December 8, 2005 in accordance with Per 134.202(c)(1). Reimbursement was not allowed for dates of service November 16, 2005 through January 18, 2006 as preauthorization was not obtained in accordance with §134.600; therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 3, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.